THE GREEN PRACTICE
WHITEFRIARS SURGERY PERTH

Dr D T Carey ▪ Dr J R Hamilton ▪ Dr N A Moloney ▪ Dr S A Elliott
Dr D N A Smith ▪ Dr J A Crichton ▪ Dr S Smith

New Patient Health Questionnaire

Surname:	**First Names:**
Date of Birth:	**Occupation:**
Next of kin: **Contact number:**	**Marital status: Single / Married / Co-habiting / Separated / Divorced / Widowed**

YOUR HEALTH

What is your height: …… your weight: ……

Have you ever suffered from any of the following:

Condition	*Please tick (✓)*	*Details*
Asthma		
Diabetes		
Epilepsy		Do you have seizures or fits? YES ☐ NO ☐ If so, when was your last seizure?
Osteoporosis		
Blindness/glaucoma		
High blood pressure		
Thyroid problems		
Stroke		
Nervous/mental breakdown		
Cancer		
Heart attack		
Angina		

THE GREEN PRACTICE
WHITEFRIARS SURGERY PERTH

Other Significant illnesses, disability or operations

Have your parents or brothers and sisters suffered from any of the above, or an inherited disease?	YES ☐ NO ☐ If yes, please state relationship and condition:

Ongoing Treatment

Are you currently receiving treatment from a hospital? YES ☐ NO ☐

If yes, please give details below including the Dr's name and hospital

Medication

Are you currently taking any tablets, medicine or injections? YES ☐ NO ☐

If yes, please give details below

(If you have a printed sheet of your current medications from your previous GP, please attach/bring with you to your appointment)

Allergies

Have you any allergies to medicines or to anything else? YES ☐ NO ☐

If Yes, please give details

THE GREEN PRACTICE
WHITEFRIARS SURGERY PERTH

Female patients only – Please tick or complete/delete appropriate sections

I currently have/have previously had a coil	YES ☐ NO ☐	
This was fitted/removed in	Date:	
Are you taking the oral contraceptive pill or using the Depo injection or implant at present?	YES ☐ NO ☐ If yes, which one:	
My last cervical smear was on Date:	Where was the smear taken?: The result was:	
I have never had a smear?	YES ☐ NO ☐	
Have you ever had a mammogram?	YES ☐ NO ☐	If yes, when?:

Lifestyle		
Smoking	**Please tick (√)**	**Comments**
I have never smoked		
Ex-smoker		
I have given up smoking		Please state when:
I currently smoke		Please state below how much you smoke?:
Would you like advice and help to stop smoking	YES ☐ NO ☐	

Drinking					
MEN: How often do you have EIGHT or more drinks on one occasion? **WOMEN**: How often do you have SIX or more drinks on one occasion? **(1 drink = ½ pint of beer or 1 glass of wine or 1 single spirits)**	**0** **Never**	**1** **Less than monthly**	**2** **Monthly**	**3** **Weekly**	**4** **Daily**

THE GREEN PRACTICE
WHITEFRIARS SURGERY PERTH

Ethnic Origin

Choose ONE section from A to E, and then tick the appropriate box to indicate your cultural background

		Please tick (√)	
A. White	Scottish		
	Other British		
	Irish		
	Other		Please specify:
B. Mixed			Please specify:
C. Asian, Asian Scottish or Asian British	Indian		
	Pakistani		
	Bangladeshi		
	Chinese		
	Other Asian		Please specify:
D. Black, Black Scottish or Black British	Caribbean		
	African		
	Other Black		Please specify:
E. Other Ethnic background			Please specify:
F. Other	Prefer not to disclose		

What is your main Language?	
If not English, do you require a translator?	YES ☐ NO ☐

CARERS:
Do you, without payment, provide help and support to a partner, child, relative, friend or neighbour, who could not manage without your help? This could be due to age, physical or mental illness, addiction or disability. YES ☐ NO ☐

Thank you for completing this form. All information given is treated as confidential. I agree to being contacted by the practice via text message to my mobile or via my email address.

Signed: …… Date: ……